A COMPARISON OF SELECTED CATASTROPHIC BILLS

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EXECUTIVE SUMMARY

This paper examines three catastrophic proposals currently under consideration by the Congress: H.R. 2941 (H.R. 2470 as amended—the House plan); H.R. 1245/S. 592 (the Bowen plan); and S. 1127 (the Senate Finance Committee (SFC) plan). It describes the proposals, presents CBO's five-year cost estimates for them, and examines their impact on enrollees for calendar year 1989.

All of the proposals would cap Medicare copayment costs, at least for services that are currently covered by Medicare, and would increase the average benefits paid by Medicare and the total premiums (either flat or income-related) paid by enrollees. Average values per enrollee for calendar year 1989 are shown below:

Plan	Copayment Cap	New Benefit	New Premiums
House	$ 1,798 1/	$ 226	$ 232
Bowen	2,150	78	82
SFC	1,773	132	141

The House plan would cover two benefits not currently covered by Medicare. It would pay 80 percent of the costs of outpatient prescription drugs above a $500 deductible, and 80 percent of the costs of in-home personal care up to a maximum of 80 hours a year. No new coverage would be provided under the Bowen or the SFC plans, although the SFC plan would allow the costs of all immunosuppressive drugs and of certain screening tests to count toward the cap.

Between 1988 and 1992, about 81 percent of new premium receipts under the House bill would be income-related, and 19 percent would be flat premiums. All of the new premium receipts under the Bowen plan would be flat. Under the SFC plan, 57 percent of new premium receipts would be income-related and 43 percent would be flat. Enrollees could avoid the new premiums under the Bowen and SFC plans by disenrolling from Part B of Medicare. The income-related portion of the new premium under the House bill would be paid by all those eligible for Part A benefits. Hence, it could not be avoided, although the new flat premiums could be avoided by disenrolling from Part B.

Only the Bowen plan would be designed to generate sufficient premium receipts to cover the costs of new Medicare benefits in every year. The automatic provisions for increasing premium rates in the House plan would be insufficient to keep pace with the costs of new benefits, and would require ad hoc premium increases to cover the shortfall, both over the five-year projection period and thereafter. Receipts under the SFC plan would fall short of costs for some years in the five-year projection period, but the plan would require that premium rates be set in 1993 and thereafter to fully cover the costs of new benefits provided under the bill each year.

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1. Composed of the SMI cap of $1,043, the hospital deductible of $580, and SNF coinsurance of $175. Copayment costs for the new drug and in-home care benefits would add to this total.

A COMPARISON OF SELECTED CATASTROPHIC BILLS

This paper provides comparative information about three bills currently under consideration in the Congress that would expand Medicare's coverage for catastrophic illnesses. The bills examined are H.R. 2941 (H.R. 2470 as amended and passed by the House on July 22); H.R. 1245/S. 592 (the Bowen/Administration plan); and S. 1127 as reported by the Senate Finance Committee on July 27.

There are three sections below. The first section describes the provisions of current law and of each of the three catastrophic bills. The second section contains CBO's cost estimates for each of the three proposals. The third section shows the impact of the Medicare benefit provisions on enrollees, while the fourth section shows the impact of the financing provisions.

The impact information in the third and fourth sections is presented for calendar year 1989, the first year that all proposals would be fully effective. Because the alternative proposals would affect different segments of the Medicare population, the numbers shown are averages or percentages for the entire Medicare population, whether they are enrolled in Part A, in Part B, or in both parts. In calendar year 1989, such enrollees will number just short of 33 million.

Unless otherwise indicated, benefit, copayment, and premium amounts are reported for all Medicare enrollees, including those who are dually eligible for Medicaid benefits. 1/ For the dually eligible group, though, copayment and premium costs are paid by Medicaid programs and new benefits under the proposals would accrue to Medicaid rather than to the enrollees. About 9 percent of Medicare enrollees are dually eligible. These dually eligible enrollees receive about 13 percent of current benefits, and would receive about 15 percent of new benefits under the proposals examined here.

DESCRIPTION OF CURRENT LAW AND CATASTROPHIC PROPOSALS

Medicare's current copayment structure is:

Under Part A Hospital Insurance (HI):

- First-day deductible of $520 (in 1987, indexed to hospital update factor) paid for the first hospital stay in each benefit period. 2/
- Hospital coverage limited to 90 days per benefit period, plus an additional 60 lifetime reserve days.

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1. An appendix is available showing results that set all reimbursement, copayment, and premium values to zero for Medicaid-Medicare beneficiaries.

2. A benefit period—or spell of illness—begins with a hospital admission, and ends on the 61st day following discharge from the hospital or from a skilled nursing facility (SNF) entered subsequent to the hospital stay. Enrollees may have up to six benefit periods during a year.

- o Coinsurance of $130 a day paid for days 61-90 in each benefit period.
- o Coinsurance of $260 a day paid for each lifetime reserve day used.
- o Nursing home stays covered only for acute care subsequent to a hospital stay, limited to 100 days in each benefit period.
- o Coinsurance of $65 a day paid for nursing home days 21-100.
- o Small coinsurance requirements for certain home health and hospice benefits.

Under Part B (SMI):

- o Initial deductible of $75 a year.
- o 20 percent coinsurance on reasonable charges above the deductible amount.

Under current law, there is no limit on enrollees' potential liabilities for copayments on Medicare-covered services. In addition to copayments, enrollees are liable for all charges above Medicare's allowed amounts on unassigned physicians' claims. Further, there are a number of health-care services that are not covered by Medicare, such as prescription drugs (except for immunosuppressive drugs provided to heart and kidney transplant patients in the first year following their transplant operation), preventive care, and long-term nursing care.

The catastrophic proposals discussed here would each expand current-law Medicare benefits, but would retain the acute-care nature of Medicare coverage. Proposals that would provide long-term care benefits are beyond the scope of this memorandum. (See Table 1 for a summary description of the benefits provided under each proposal.)

House Plan (H.R. 2941)

Benefits. The House proposal would eliminate the spell of illness concept and would reduce copayment requirements under the HI program effective January 1, 1988, while introducing a cap on copayments for the SMI program effective January 1, 1989. The SMI copayment cap would be set at $1,043 in 1989, indexed to the COLA (the cost-of-living adjustment made each year to Social Security payments) in subsequent years.

The HI deductible would be indexed to the hospital update factor as under current law. Enrollees would pay a deductible only for the first hospital stay each year, and there would be no hospital coinsurance payments required. Further, the current limit on covered hospital days would be eliminated.

TABLE I. DESCRIPTION OF MEDICARE BENEFITS AND FINANCING MECHANISMS UNDER CURRENT LAN AND SELECTED CATASTROPHIC PROPOSALS, 1989

Provision	Current Law	House Proposal	Bowen/Administration Proposal	Senate Finance Committee Proposal
HOSPITAL INSURANCE		H.R. 2941	H.R. 1245 / S. 592	S. 1127
Coverage	Hospital inpatient care Short-term skilled nursing care Intermittent hole health care Hospice care for terminally ill	Same as current law, with changes noted under limits to coverage	Same as current law, with changes noted under limits to coverage	Same as current law, with changes noted under limits to coverage
Liiits to coverage	Hospital stays covered up to 90 days per benefit period, plus up to 60 lifetime reserve days; benefit periods unlimited in number Lifetime limit of 190 days for inpatient psychiatric care SNF stays covered up to 100 days per benefit period, following hospital stay Lifetiie limit of 210 days for hospice benefits	No liiit on covered inpatient stays (except for psychiatric care) SNF limit changed from 100 days/spell to 150 days/year Prior hospitalization requirement eliminated for SNF stays Lifetiie limit on hospice days eliminated Hone health care permitted for up to 35 consecutive days	No limit on covered inpatient stays (except for psychiatric care) SNF lint changed froi 100 days/spell to 100 days/year	No liiit on covered inpatient stays (except for psychiatric care) SNF lint changed froa 100 days/spell to 150 days/year Prior hospitalization requirement eliminated for SNF stays Lifetime limit on hospice days eliminated How health care permitted for up to 21 consecutive dan for all enrollees, & up to 45 days for enrollees with prior hospital stay
Deductibles	First-day deductible ($580 in 1989) paid for first hospital stay in each benefit period Blood deductible of up to 3 units paid in each benefit period	First-day deductible ($580 in 1989) paid only for first stay/year Blood deductible changed to S/year	First-day deductible ($580 in 1989) paid only for first 2 stays/year if not limited by copayment Cap	First-day deductible ($580 in 1989) paid only for fir»t stay/year if not limited by copayment Cap Blood deductible changed to 3/year
Coinsurance	Coinsurance paid for hospital days 61-90 (1/4 deductible aaount) and reserve days (1/2 deductible amount) Coinsurance paid for SNF days 21-100 (1/8 deductible aiountl Coinsurance of 5 percent of charges for drugs and respite care provided by hospices	No coinsurance for hospital stays SNF coinsurance changed to 20% of reasonable costs for first 7 days each year	No coinsurance for hospital or for SNF stays	No coinsurance for hospital stays SNF coinsurance changed to 15% of reasonable costs for first 10 days each year
SUPPLEMENTARY MEDICAL INSURANCE				
Coverage	Physicians' services Outpatient departments Ambulatory surgicenters Laboratory services Hone health care	Expanded to include outpatient prescription drugs and in-hone personal care	Same as current law	Same at current law
Liiits to coverage	Most preventive care not covered Eyeglasses, hearing aids, and outpatient prescription drugs not covered except in certain cases (i.e. cataract patients, transplant patients in first year) Reimbursement liiit of $250/year on outpatient psychiatric care	Reimbursement liiit for psychiatric care increased to $1000/year In-hone care limited to BO hours/year	Same as current law	Sale as current la*
Deductibles	Annual deductible of $75	Separate $500 deductible for drugs	San as current law	Same as current IN
Coinsurance	Coinsurance of 20 percent of reasonable charges above the deductible amount (50 percent for outpatient psychiatric services)	Same as current law; 20 percent coinsurance applied to new drug and in-hone care benefits as Nell	Same as current la«	Same as current law
COPAYMENT CAP	None	Cap of $1043 (1989), SMI only Cap indexed to COLA	Cap of $2150 (1989), HI+SMI Cap indexed to per-enrollee growth in Medicare reimbursements	Cap of $1773 (1989), HI+SMI Cap indexed to COLA Cost of iaounosuppressive drues after 1st year and of certain screening tests count to cap
FINANCING MECHANISMS	Ta« revenues and flat preiiuas	Income-related and flat preiiuis	Flat preiiuas	Income-related and flat preiiuis

SOURCE: CONGRESSIONAL BUDGET OFFICE

Up to 150 days a year would be covered for SNF stays, and SNF coinsurance payments would be set at 20 percent of the approved cost per day for the first seven days each year, rather than at one-eighth the hospital deductible for days 21-100 in each benefit period as under current law. The current requirement for a 3-day prior hospital stay to receive Medicare coverage for a SNF stay would be eliminated.

In addition, the current 210-day lifetime limit on hospice benefits for terminally ill enrollees would be eliminated. Home health benefits would be expanded to permit up to 35 consecutive days of care. The blood deductible requirement would be changed to 3 units a year, instead of 3 units each benefit period. The current limit of $250 in Medicare reimbursements for outpatient mental health services would be increased to $1,000. The coinsurance rate for mental health benefits would remain at 50 percent, though, and the additional copayments that would result under this provision would not count toward the SMI copayment cap.

The House bill would provide coverage for two services not currently covered by Medicare—outpatient prescription drugs and in-home personal care for those too incapacitated to be left alone. Under the drug benefit, Medicare would reimburse 80 percent of reasonable costs above a deductible amount, which would be $500 in 1989 and indexed to a drug price index in subsequent years. Under the in-home care benefit, Medicare would reimburse 80 percent of costs for a total of up to 80 hours of care each year. None of the copayment costs for these two benefits would count toward the SMI copayment cap. The in-home care benefit would expire at the end of calendar year 1991.

Financing. Additional benefits would be financed through premium increases, in three parts—new outlay-based premiums, a new income-related premium, and ad hoc premium increases.

All of the outlay costs of the new in-home personal care benefit, and 75 percent of the outlay costs of the new drug benefit would be financed by new outlay-based premiums. 3/ In 1989, these additional premiums would amount to $2.60 monthly—$2.30 for the drug benefit and $0.30 for the in-home care benefit.

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3. Current SMI premiums are based on incurred costs, rather than outlay costs. The difference between incurred and outlay costs is due to lags in payment for services provided. When premiums are based on incurred costs, all expected costs for covered services used during a year are paid by that year's beneficiaries. When premiums are based on outlay costs, premiums paid by beneficiaries in the first year will typically not cover the costs of the services they received. Instead, part of the costs of services used by beneficiaries in one year will be paid from premiums paid by the next year's enrollees.

In addition, all taxpayers eligible for benefits under Part A of Medicare would pay a supplemental income-related premium through the income tax system, first effective for 1988. The income-related premium would not be eligible for the medical expense deduction provided in current law. Enrollees filing individual returns for 1988 would pay an amount equal to $10 for each $143 of adjusted gross income (AGI) in excess of $6,000, up to a maximum annual liability of $580. In subsequent years, the basic premium rate and the ceiling on liability would be indexed to growth in the subsidy value of Medicare benefits (excluding the drug and in-home care benefits). 4/ Beginning in 1989, the basic premium rate would also be increased by an amount sufficient to pay 25 percent of the outlay costs of the drug benefit. In addition to annual adjustments to the premium rate, the AGI parameters of $143 and $6,000 would be indexed to the Consumer Price Index. As a result, for 1989 Part A enrollees would pay an estimated $12.60 for each $149 of AGI above $6,258, up to a maximum of $730.

Growth in income-related premium receipts would not keep pace with growth in new Medicare benefits under the House bill, for two reasons. First, nominal premium rates would be indexed to the rate of growth in the subsidy value of total Medicare benefits, which would grow less rapidly than the subsidy value of new benefits provided under this bill. Second, effective premium rates would grow even less rapidly than nominal premium rates, because the AGI brackets for the premiums would be indexed to the CPI. As a result, the House bill would result in net costs to Medicare of $290 million by 1992, were it not for the ad hoc premium increases specified in the bill ($1.00 a month in 1991 and $1.30 in 1992). These ad hoc increases would become part of the base that was indexed to the COLA for 1993 and all subsequent years.

Eligibility. The new HI benefits under this proposal would be provided to all those eligible for Part A benefits. The new SMI benefits, including the copayment cap, would apply only to those enrolled under Part B of Medicare. Unlike the other catastrophic proposals discussed here, there would be no need to administer a two-track HI system, or to retain administrative information on benefit periods and hospital coinsurance or reserve days.

Bowen/Administration Plan (H.R. 1245 and S. 592)

Benefits. The Bowen/Administration proposal would eliminate the spell of illness concept, and would also eliminate all copayment requirements under the HI program except for the hospital deductible, which would be limited to at most two a year. Indexation of the HI deductible amount would be unchanged from current law. The proposal would cap copayments for HI and SMI combined at $2,000 in 1988, with the amount of the cap indexed to growth in Medicare reimbursements per enrollee.

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4. The subsidy value of Medicare benefits is defined as 50 percent of the per-enrollee value of HI benefits, plus the excess of per-enrollee SMI benefits over (flat) premium amounts.

Apart from eliminating the limit on covered hospital days, there would be no expansion of coverage to new services. In fact, for a very small number of enrollees (two to three hundred) coverage for SNF benefits would drop. Currently, up to 100 SNF days per benefit period are covered, while under this proposal no more than 100 days a year would be covered.

Financing. This proposal calls for new benefits to be financed entirely by an additional flat premium--a catastrophic premium--that would be distinct from the basic SMI premium. The full package of catastrophic benefits, and the additional premium, would apply to all those who enrolled in the SMI program. The catastrophic premium would be increased each year by whatever amount was projected as necessary to pay for catastrophic benefits.

Eligibility. Those who were eligible only for HI benefits would not be protected by the copayment cap. They would, however, benefit from the new HI copayment structure even though they would pay no catastrophic premium. Thus, it would not be necessary to retain the old HI structure for HI-only enrollees. It would be necessary, though, to retain or impute information on benefit periods, hospital coinsurance and reserve days, and SNF coinsurance days in order to determine each year the costs of the new benefits provided under this bill--and hence the amount of the catastrophic premium.

Senate Finance Committee Plan (S. 1127)

Benefits. The Senate Finance Committee (SFC) proposal would cap copayments under HI and SMI combined, while reducing copayment requirements under the HI program by limiting payment of the HI deductible to the first stay each year and eliminating hospital coinsurance requirements and the limit on covered hospital days. The copayment cap would be set at $1,700 a year in 1988, and indexed thereafter to increases in the COLA. For 1988 the cap would apply only to copayments incurred during the last six months of the year. Thereafter, the cap would apply to copayments incurred during the entire calendar year.

The costs of immunosuppressive drugs for transplant patients would count toward the copayment cap every year, but (as under current law) would not be covered beyond the first year following the transplant operation. In addition, the costs of certain cancer screening exams would be counted toward the copayment cap. These would include annual colorectal examinations for all enrollees age 65 or more, and triennal mammograms for enrollees age 55 or more.

The spell of illness concept would be eliminated, but enrollees who paid a hospital deductible in December of one year would not have to pay another deductible if readmitted to the hospital in January of the next year. Up to 150 days a year would be covered for SNF stays, and SNF coinsurance

payments would be set at 15 percent of the approved cost per day for the first ten days each year. Home health benefits would be provided for up to 21 consecutive days for all enrollees, and up to 45 days for enrollees discharged from the hospital within the previous 30 days. The 210-day lifetime limit on hospice benefits would be eliminated, and the blood deductible would be changed to 3 units a year.

Financing. New benefits would be financed by a two-part additional premium for SMI enrollees, similar to the mechanism already described for the House bill. All SMI enrollees would pay a new catastrophic flat premium of $4.00 a month in 1988 (effective in April). This premium would be separate from the current SMI premium, and would be indexed to increases in the per-enrollee value of catastrophic benefits.

In addition, SMI enrollees with income tax liability of $150 or more would pay a supplemental income-related premium designed to cover the remaining costs of the new benefits. This premium would be eligible for the medical expense deduction. The income-related premium rate would be $12.20 for each $150 of tax liability in 1988, up to a maximum liability of $800 per enrollee. The premium rate would be indexed to the rate of growth in catastrophic benefits per enrollee, so that it would increase to $13.60 for 1989. The maximum liability would also increase, to $850. Because the income-related premium would be a deductible expense, and because of the ceiling on liability, which would increase less rapidly than the growth in benefits provided under this bill, receipts would not keep pace with benefits over the first five years.

Beginning in 1992, the bill would require that premium rates (flat and income-related combined) be set to fully cover the costs of new benefits provided under the bill each year. Hence, the SFC bill would not contribute to the deficit beyond the five-year projection period. This would probably mean, however, that premium rates would increase faster than they would if the indexing mechanisms in place from 1988 through 1992 were unchanged.

Eligibility. This proposal would retain the current HI benefit structure for Hi-only enrollees. Hence, a two-track HI program would exist. In addition, information on spells of illness, hospital coinsurance and reserve days, and SNF coinsurance days under current law would have to be imputed in order to compute catastrophic premium increases.

ESTIMATES OF COSTS AND RECEIPTS UNDER THE PROPOSALS

CBO's five-year projections for additional Medicare costs, premium receipts, and Medicaid costs under the three proposals are shown in Table 2. The Bowen benefit package would be the least expensive, with five-year total benefit costs of $13.0 billion. One aspect of the Bowen plan has not yet been estimated, though, and this could increase its costs substantially. This is the provision in the bill that would permit enrollees to substitute

TABLE 2. COSTS AND RECEIPTS UNDER SELECTED CATASTROPHIC PROPOSALS, 1988-1992 (Fiscal year outlays, in millions of dollars)

Proposal	1988	1989	1990	1991	1992	Total 1988-92
House Plan						
Medicare Benefits	1,050	4,790	7,445	8,945	10,155	32,385
Administrative Costs	156	186	182	187	192	902
Premiums:						
Flat Premiums a/	10	-775	-1,435	-2,055	-2,280	-6,535
Income-related	-1,420	-5,170	-6,450	-7,375	-8,265	-28,680
Subtotal	-205	-970	-258	-298	-198	-1,928
Effect of Medicare Provisions on Medicaid Costs	-85	-355	-540	-635	-725	-2,340
Other Medicaid	125	560	655	750	835	2,925
Total	-165	-765	-143	-183	-88	-1,343
Bowen/Administration Plan b/						
Medicare Benefits	1,400	2,380	2,755	3,065	3,405	13,005
Administrative Costs	60	20	20	20	20	140
Premiums:						
SMI Premiums	-1,735	-2,555	-2,820	-3,135	-3,485	-13,730
Income-related	0	0	0	0	0	0
Subtotal	-275	-155	-45	-50	-60	-585
Effect of Medicare Provisions on Medicaid Costs	-30	-70	-90	-95	-110	-395
Other Medicaid	0	0	0	0	0	0
Total	-305	-225	-135	-145	-170	-980
Senate Finance Committee Plan						
Medicare Benefits	1,385	3,510	4,825	5,715	6,665	22,100
Administrative Costs	69	24	24	24	24	160
Premiums:						
SMI Premiums	-760	-1,685	-1,945	-2,285	-2,655	-9,330
Income-related	-660	-2,300	-2,660	-3,135	-3,620	-12,375
Subtotal	34	-451	244	319	414	560
Effect of Medicare Provisions on Medicaid Costs	-75	-205	-300	-360	-420	-1,360
Other Medicaid	10	145	290	295	65	805
Total	-31	-511	234	254	59	5

SOURCE: Congressional Budget Office.

a. Includes outlay-based SMI premiums, ad hoc SMI premiums, and change in HI premium calculation.

b. Costs for fourth quarter substitution of copayments not estimated.

their copayment costs for the fourth quarter of the previous year, in place of their copayment costs for the fourth quarter of the current year, if that would be to their advantage. The House plan would be the most expensive, totalling $32.4 billion over the five-year projection period. Five-year costs for the Senate Finance Committee plan would be $22.1 billion.

Adequacy of Financing for New Medicare Benefits. The automatic financing mechanisms for the new Medicare benefits would be adequate for each year over the five-year projection period only for the Bowen plan, under which the incurred costs of all new benefits would be funded by additional flat premiums with rates indexed to the rate of growth in new benefits. Under both the House and the SFC plans the indexing, ceiling, and deductibility provisions for the income-related premiums would cause premium receipts to fall short of the costs for new benefits, unless augmented by ad hoc premium increases.

The disparity in growth rates between benefits and automatic premium increases would be larger for the House plan than for the SFC plan. This is not apparent from the figures shown in Table 2 because of the larger initial excess of receipts over benefits and because of the ad hoc premium increases mandated for 1991 and 1992 in the House bill.

A better picture of the disparity in growth rates can be seen by comparing the growth in benefits and automatic premium receipts between 1991 and 1992, as an indication of disparities that could arise beyond the five-year projection period if ad hoc adjustments to premium rates were not made (Table 3). For this comparison, both benefits and receipts due to drug

TABLE 3. COMPARISON OF RATES OF GROWTH FOR BENEFITS AND AUTOMATIC RECEIPTS UNDER SELECTED CATASTROPHIC PROPOSALS, FISCAL YEARS 1991 TO 1992

Growth in	House Plan a/	Bowen Plan	SFC Plan
New Benefits	16.6	11.1	16.6
Automatic Premium Receipts			
Flat	--	11.1	16.2
Income-related	12.5	--	15.5
Total	12.5	11.1	15.8
Excess in Rate of Growth of Benefits Over Receipts	4.1	0.0	0.8

SOURCE: Congressional Budget Office

a. Excludes benefits and receipts for drug and in-home care benefits, because these are designed to be fully financed by premiums in all years.

and in-home care benefits provided under the House bill have been excluded, because under the bill these benefits would be fully funded by special premium receipts in all years. The ad hoc premium increases provided under the House bill were excluded because the intent is to determine how much more rapidly benefits would grow relative to premium receipts that would arise automatically under the indexing provisions specified in the bills.

Under the House plan, new benefits would grow by 16.6 percent from 1991 to 1992, while automatic premium receipts would grow by 12.5 percent. This means that if receipts and benefit costs were equal in 1992, at $1 billion say, then receipts would fall short of benefit costs in 1992 by 4.1 percent, or $41 million, unless augmented by ad hoc increases in premiums.

Under the SFC plan, new benefits would grow by 16.6 percent, while automatic premium receipts would grow by 15.8 percent from 1991 to 1992. Continuing the example given above, if receipts and benefit costs were equal at $1 billion in 1991, receipts would fall short of benefits in 1992 by 0.8 percent, or $8 million, unless augmented by ad hoc premium increases. Beginning in 1993, though, the SFC plan would require that premium rates be adjusted to fully cover the costs of catastrophic benefits, regardless of the rates that would result under the indexing provisions used for previous years. Hence, receipts would keep pace with benefit costs after 1992, but premium rates would probably have to increase about 5 percent faster than they would under the automatic indexing provisions.

Copayment Parameters. The values that would determine copayment rates under current law and under each of the proposals are shown in Table 4. Under current law and each of the three proposals, the hospital deductible would be indexed to the hospital update factor. It would grow from $520 in 1987, to $544 in 1988, and to $700 by 1992. These values and projected reasonable costs per SNF day are shown only once, for current law.

Under current law, coinsurance rates per SNF day are set at one-eighth the hospital deductible amount. Hence, the daily coinsurance rate would be $68.00 in 1988 under current law. Under the House and Senate Finance Committee proposals, SNF coinsurance rates would be keyed to reasonable costs per day. The coinsurance rate under the House plan would be 20 percent, resulting in daily coinsurance payments of $23.50 in 1988. Under the Senate Finance Committee plan, the coinsurance rate would be 15 percent, with daily coinsurance payments equal to $18.00 in 1988. There would be no SNF coinsurance under the Bowen plan.

Under all but the Bowen plan, the copayment cap would be indexed to the COLA. Under the Bowen plan, the copayment cap would be indexed instead to the rate of growth in Medicare reimbursements per enrollee, with the result that the cap would grow more rapidly. By 1992, the copayment cap under the Bowen plan would be $2,900, while it would be $2,014 under the Senate Finance Committee plan. Unlike the other plans, where the cap

TABLE 4. PROJECTED COPAYMENT PARAMETERS UNDER CURRENT LAW AND SELECTED CATASTROPHIC PROPOSALS, 1988-92 (Calendar year amounts, in dollars)

Proposal	1988	1989	1990	1991	1992
Current Law					
Hospital Deductible	544	580	620	660	700
Reasonable Cost Per SNF Day	118	126	134	141	149
SNF Coinsurance Per Day	68.00	72.50	77.50	82.50	87.50
Copayment Cap	na	na	na	na	na
House Plan					
SNF Coinsurance Per Day	23.50	25.00	27.00	28.00	30.00
Copayment Cap a/	na	1,043	1,089	1,136	1,185
Bowen/Administration Plan					
SNF Coinsurance Per Day	0	0	0	0	0
Copayment Cap	2,000	2,150	2,400	2,630	2,900
Senate Finance Committee Plan					
SNF Coinsurance Per Day	18.00	19.00	20.00	21.00	22.00
Copayment Cap b/	1,700	1,773	1,851	1,931	2,014

SOURCE: Congressional Budget Office.

a. Cap would apply only to SMI copayments.
b. Cap would apply only for the last half of 1988.

would apply to copayments under either part of Medicare, the cap under the House plan would apply only to SMI copayments and would reach $1,185 by 1992.

Premium Parameters. The premiums that would be paid by Medicare enrollees under current law and the three catastrophic proposals are shown in Table 5. Under current law, the flat SMI premium would be $22.00 monthly in 1988, growing to $26.00 monthly by 1992. This is paid only by Part B enrollees. There is no income-related premium under current law.

Under the House plan, SMI enrollees would pay additional outlay-based flat premiums of $2.60 a month beginning in 1989, to fund all of the in-home care benefit and 75 percent of the outpatient drug benefit. This premium would increase to $3.90 a month in 1990. In 1991, SMI enrollees would pay an ad hoc premium increase of $1.00 a month, in addition to the outlay-

TABLE 5. PREMIUMS PER ENROLLEE UNDER CURRENT LAW AND SELECTED CATASTROPHIC PROPOSALS (Calendar year amounts, in dollars per enrollee)

Proposal	1988	1989	1990	1991	1992
Current Law					
Current Law Flat Premiums					
Monthly	22.00	22.90	23.90	24.90	26.00
Annual	264.00	274.80	286.80	298.80	312.00
Income-Related Premiums					
Maximum annual liability	0.00	0.00	0.00	0.00	0.00
House Plan					
New Flat Premiums					
Monthly	0.00	2.60	3.90	5.40	5.50
Annual	0.00	31.20	46.80	64.80	66.00
Income-Related Premiums					
Maximum annual liability	580.00	730.00	826.00	911.00	993.00
Bowen/Administration Plan					
New Flat Premiums					
Monthly	6.10	6.80	7.30	8.00	8.70
Annual	73.20	81.60	87.60	96.00	104.40
Income-Related Premiums					
Maximum annual liability	0.00	0.00	0.00	0.00	0.00
Senate Finance Committee Plan					
New Flat Premiums					
Monthly	4.00	4.50	5.10	5.90	6.70
Annual	48.00	**54.00**	61.20	70.80	80.40
Income-Related Premiums					
Maximum annual liability	800.00	850.00	900.00	950.00	1,000.00

SOURCE: Congressional Budget Office.

based premium of $4.40, for a total premium increase above current law of $5.40. In addition, HI enrollees with taxable income would be subject to an income-related premium. The maximum liability for any enrollee under the income-related premium would be set at $580 for 1988, with the maximum increased in subsequent years based on the rate of growth in the subsidy value of all Medicare benefits, including that portion of costs for the drug benefit not financed by a flat premium.

The Bowen proposal would be fully financed by additional flat premiums. Under the Bowen plan, the additional premium would be an estimated $6.10 a month in 1988, rising to $8.70 a month by 1992.

Like the House plan, the Senate Finance Committee plan would be financed by a combination of additional flat premiums and an income-related premium. The additional flat premium would be $4.00 a month in 1988 (beginning in April), and the maximum income-related premium would be $800 a year. By 1992, the additional flat premium would be an estimated $6.70 a month, and the maximum income-related premium would be $1,000 a year.

IMPACT ON ENROLLEES FROM BENEFIT PROVISIONS

Under current law, CBO estimates that the average benefit per Medicare enrollee will be $3,113 in calendar year 1989. The average Medicare copayment will be $524. In addition, Medicare enrollees will pay $265, on average, for outpatient prescription drugs. Drug costs are not included as a part of Medicare copayments shown here.

Under the House proposal, benefits per enrollee would increase by 7 percent relative to current law. Under the Bowen proposal, benefits would increase by 3 percent, while they would increase by 4 percent under the Senate Finance Committee proposal. The benefit increases represent, in large part, a transfer of copayment and drug costs from enrollees to Medicare. 5/ Average enrollee copayment costs would be only 75 percent of current law amounts under the House proposal, 86 percent of current law under the Bowen proposal, and 78 percent of current law under the Senate Finance Committee proposal. The proportion of enrollees who would be affected by the copayment caps (that is, who would have some portion of their copayment liabilities assumed by Medicare) would vary from 5.2 percent under the Bowen proposal, to 8.1 percent under the House proposal (Table 6).

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5. In addition to the copayment costs assumed by Medicare, benefits would increase due to enrollees' increased used of services following reduction or elimination of cost sharing.

TABLE 6. BENEFITS AND COPAYMENTS PER ENROLLEE UNDER CURRENT LAW AND SELECTED CATASTROPHIC PROPOSALS, 1989

	Current Law	House Plan	Bowen Plan	SFC Plan
Average Benefit ($)	3,113	3,339	3,191	3,245
Relative to current law	1.00	1.07	1.03	1.04
Change in Average Benefit ($)	0	226	78	132
Average Copayment ($)	524	391	452	409
Relative to current law	1.00	0.75	0.86	0.78
Average Enrollee Drug Costs ($)	265	193	265	265
Relative to current law	1.00	0.73	1.00	1.00
Percent of Enrollees Affected by Copayment Cap a/	0.0	8.1	5.2	6.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

a. Under the House plan, the copayment cap would apply only to SMI copayments. All others would apply to HI and SMI copayments together.

All of the proposals would succeed in eliminating very high copayment costs for enrollees. Under current law, the distribution of copayment costs is very uneven, with 30 percent of enrollees incurring little or no costs, while about 0.5 percent of enrollees with long or multiple hospital stays will incur copayment costs of about $8,000, on average, in 1989. Under all of the catastrophic proposals, the very high copayment costs of those enrollees at the high end of the distribution would be capped (Table 7).

TABLE 7. MEDICARE COPAYMENTS BY USE OF SERVICES, 1989 (In dollars per enrollee)

Enrollee Group	Percent of Enrollees in Group	Current Law	House Plan	Bowen Plan	SFC Plan
By Use of Services a/					
No reimbursable services	29.1	23	23	23	23
No stays, other services	49.0	293	247	274	268
One stay, no coinsurance	14.6	1,250	1,112	1,167	1,130
2+ stays, no coinsurance	6.9	2,211	1,375	1,922	1,426
1+ stays, coinsurance days	0.5	8,164	1,499	1,916	1,619
All Enrollees	100.0	524	391	452	409

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

a. The use groups are defined in terms of current law.

About 3.5 percent of enrollees will incur copayment costs in excess of $2,500 in 1989, under current law. Under the House and the Bowen plans, no enrollees would face Medicare copayment costs above $2,500. Under the Senate Finance Committee plan, no SMI enrollees would incur copayment costs above $2,000, but a very small number of HI-only enrollees (who would not be affected under the Senate Finance Committee bill) would incur copayment costs of $3,000 or more (Table 8).

TABLE 8. PERCENT DISTRIBUTION OF ENROLLEES BY COPAYMENT LIABILITY, 1989

Copayment Class (In dollars per enrollee)	Current Law	House Plan	Bowen Plan	SFC Plan
$0	3.2	3.2	3.2	3.3
$1-100	39.2	39.2	39.2	39.2
$101-200	22.3	22.2	22.2	22.2
$201-500	7.7	7.5	7.5	7.5
$501-1,000	10.9	11.5	10.4	11.5
$1,001-1,500	7.3	9.5	6.7	8.3
$1,501-2,000	3.9	6.9	4.7	8.1
$2,001-2,500	2.0	0.0	6.1	0.0
$2,501-3,000	1.2	0.0	0.0	0.0
$3,001 or more	2.3	0.0	0.0	*
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

* Less than .05 percent.

Although copayments would fall, on average, under each of the three proposals, individual enrollees could face either a rise, a fall, or no change in their copayment costs. Under the House proposal, 1 percent of enrollees would face an increase in copayment costs in 1989 that would vary from a few dollars to more than $1,000; 10 percent of enrollees would see their copayment costs fall by amounts ranging from a few dollars to more than $3,000; and 89 percent of enrollees would experience no change in copayment costs (Table 9).

Those enrollees who would experience an increase in copayment costs would do so for one of two reasons. First, some enrollees would pay a hospital deductible that they would not pay under current law because of the elimination of the spell of illness concept. This effect is largest under the Bowen proposal, which would require up to two deductibles to be paid each

TABLE 9. PERCENT DISTRIBUTION OF ENROLLEES BY CHANGE IN COPAYMENT LIABILITIES, 1989

	House Plan	Bowen Plan	SFC Plan
Average Change in Copayment Liability	-133	-72	-116
Percent of Enrollees for Which Copayments Would Decrease By:			
$1-250	1.7	0.9	1.1
$251-500	1.3	0.7	0.8
$501-1,000	3.5	1.1	3.0
$1,001-2,000	1.9	0.9	1.5
$2,001-3,000	0.6	0.4	0.5
$3,001 or more	1.0	0.8	0.9
Total	10.0	4.9	7.9
Percent of Enrollees for Which Copayments Would Increase By:			
$1-250	0.4	0.3	0.3
$251-500	0.1	0.4	0.1
$501-1,000	0.6	2.5	0.6
$1,001-2,000	0.0	0.1	0.0
$2,001-3,000	0.0	0.0	0.0
$3,001 or more	0.0	0.0	0.0
Total	1.0	3.3	1.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

year while all other proposals would require no more than one each year. Under the Bowen proposal, about 4.7 percent of enrollees would be liable for a second deductible that they would not be liable for under current law (Table 10). Because of the cap, though, only 3.3 percent of enrollees would actually pay more than under current law.

TABLE 10. PERCENT DISTRIBUTION OF ENROLLEES BY HI DEDUCTIBLES INCURRED, 1989

	Current Law	House Plan	Bowen Plan	SFC Plan
Percent of Enrollees Who Would Incur HI Deductibles Equal to:				
0	79.0	78.1	78.1	78.1
1	17.7	21.9	14.7	21.9
2	2.9	0.0	7.2	*
3 or more	0.4	0.0	0.0	0.0
Percent of Enrollees for Which Deductibles Incurred Would:				
Decrease	0.0	3.3	0.4	3.3
Not change	100.0	95.7	95.0	95.8
Increase	0.0	1.0	4.7	1.0
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

* Less than .05 percent.

Another reason that copayments would increase for some enrollees is that, at least under the House and the Senate Finance Committee plans, enrollees with short SNF stays might pay SNF coinsurance that they would not pay under current law, because of the shift in coinsurance requirements from the last days to the first days of SNF stays. This would amount to less than $200 per enrollee, though, and fewer than 1 percent of enrollees would be affected.

Another, still small, impact from changes in the provisions applicable to SNFs relates to the number of SNF days covered under alternative proposals. (Enrollee costs for SNF days not covered by Medicare are not included in copayment costs.) Under the House and the Senate Finance Committee proposals, about 7,880 enrollees would experience an increase in the number of SNF days covered by Medicare, while about 120 enrollees would see a fall in covered days. Under the Bowen proposal, no one would receive more covered days, but about 240 enrollees would see their covered days fall because of the change in the coverage limit from 100 days a spell to 100 days a year.

The benefit increases that would occur under all three plans would be larger for lower income enrollees. Under the House plan, the average increase in benefits would be $226, varying from $243 for those with family incomes below $5,000 to $209 for those with incomes above $50,000. The average increase in benefits under the Senate Finance Committee plan would be $132 in 1989, but it would be $170 for poor enrollees and only $118 for nonpoor enrollees (Table 11).

TABLE 11. AVERAGE BENEFITS BY INCOME AND POVERTY STATUS, 1989 (In dollars per enrollee)

	Average Benefit	Change in Average Benefit		
	Current Law	House Plan	Bowen Plan	SFC Plan
By Family Income				
Under $5,000	3,031	243	95	151
$5,000-10,000	3,447	254	96	157
$10,000-15,000	3,291	234	83	140
$15,000-20,000	3,274	228	75	132
$20,000-30,000	2,903	216	73	124
$30,000-$50,000	2,808	210	70	119
$50,000 or more	3,017	209	60	114
By Poverty Status				
Poor	3,354	265	110	170
Near poor a/	3,621	256	95	159
Nonpoor	2,922	210	67	118
All Enrollees	3,113	226	78	132

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

Changes in copayment and drug cost liabilities under the proposals are the mirror image of changes in benefits. Copayment and drug cost reductions are larger for lower income groups (Table 12).

TABLE 12. AVERAGE COPAYMENT AND DRUG COST LIABILITIES BY INCOME AND POVERTY STATUS, 1989 (In dollars per enrollee)

	Average Liability	Change in Average Liability		
	Current Law	House Plan	Bowen Plan	SFC Plan
By Family Income				
Under $5,000	793	-224	-92	-136
$5,000-10,000	852	-232	-90	-140
$10,000-15,000	815	-212	-78	-124
$15,000-20,000	806	-203	-68	-114
$20,000-30,000	750	-194	-66	-107
$30,000-50,000	743	-189	-64	-103
$50,000 or more	774	-189	-56	-99
By Poverty Status				
Poor	840	-243	-102	-150
Near poor a/	865	-231	-89	-141
Nonpoor	758	-189	-61	-102
All Enrollees	789	-205	-72	-116

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

A disproportionate share of benefits—both current and new—would accrue to disabled enrollees, especially those with chronic renal disease. Disabled enrollees comprise about 10 percent of all Medicare enrollees, but would receive from 17 percent to 27 percent of new benefits under the three catastrophic proposals examined. Enrollees with renal disease, both aged and disabled, make up about 0.4 percent of enrollment, but would receive at least 11 percent of new benefits (Table 13).

TABLE 13. PERCENT OF BENEFITS RECEIVED BY TYPE OF ENROLLEE, 1989

	Percent of Enrollees in Group	Percent of Current Benefits Current Law	Percent of New Benefits Received House Plan	Bowen Plan	SFC Plan
Aged Enrollees					
Without renal disease	90.2	86.4	79.4	62.5	72.4
With renal disease	0.1	1.6	3.8	9.5	6.0
Disabled Enrollees					
Without renal disease	9.4	9.4	9.8	10.2	10.2
With renal disease	0.3	2.6	6.9	17.1	11.5
All Enrollees, by Age					
Less than 65	10.1	12.4	17.4	27.8	22.0
65-69	28.0	20.2	20.9	17.9	18.2
70-74	23.4	22.1	21.2	19.2	20.0
75-79	17.4	19.1	18.0	15.9	17.2
80-84	11.4	13.8	12.2	10.3	12.0
85 or more	9.7	12.2	10.2	8.6	10.6
Total	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. All HI and/or SMI enrollees are included.

From 12 percent to 13 percent of all Medicare enrollees are poor, but these enrollees would receive from 15 percent to 18 percent of new benefits under the proposals. Those with incomes more than 1.5 times the poverty line comprise about 70 percent of all enrollees; this group would receive about 60 percent of new benefits under each of the catastrophic proposals (Table 14).

TABLE 14. PERCENT OF BENEFITS RECEIVED BY INCOME AND POVERTY STATUS, 1989

	Percent of Enrollees in Class	Percent of Current Benefits	Percent of New Benefits Received		
		Current Law	House Plan	Bowen Plan	SFC Plan
By Family Income					
Under $5,000	2.4	2.4	2.6	3.0	2.8
$5,000-10,000	17.5	19.4	19.7	21.5	20.8
$10,000-15,000	18.1	19.1	18.7	19.2	19.2
$15,000-20,000	12.7	13.3	12.8	12.2	12.7
$20,000-30,000	17.9	16.6	17.1	16.7	16.8
$30,000-50,000	19.8	17.9	18.4	17.8	17.9
$50,000 or more	11.7	11.3	10.8	9.0	10.1
By Poverty Status					
Poor	12.8	13.8	15.0	18.0	16.4
Near poor a/	19.4	22.5	21.9	23.6	23.0
Nonpoor	67.9	63.7	63.1	58.3	60.7
Total	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All HI and/or SMI enrollees are included.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.

One of the criticisms made about the catastrophic proposals examined here is that the copayment limits are the same for all enrollees, regardless of income, although even relatively small out-of-pocket costs could be catastrophic for low-income enrollees who were not eligible for Medicaid. Table 15 shows the percent distribution of nonMedicaid enrollees by a measure of the burden that Medicare copayments and out-of-pocket costs for drugs would impose on them. This measure is the ratio of copayment and drug costs per enrollee over per capita income.

Under current law, in 1989 77.6 percent of nonMedicaid enrollees would have copayment and drug liabilities that total less than 10 percent of their per capita income, while 10.4 percent of enrollees would have liabilities that total more than 20 percent of their per capita income.

The House plan would reduce the share of enrollees with liabilities in excess of 20 percent of their per capita income to 6.7 percent. The Bowen plan would reduce that share to 10.1 percent, and the SFC plan would reduce the share to 8.9 percent.

TABLE 15. PERCENT DISTRIBUTION OF NONMEDICAID ENROLLEES BY RATIO OF COSTS FOR COPAYMENTS AND DRUGS TO PER CAPITA INCOME, 1989

Costs as a Percent of Per Capita Income	Current Law	House Plan	Bowen Plan	SFC Plan
Under 10 Percent	77.6	80.8	77.3	78.2
10 Percent to 20 Percent	12.1	12.6	12.6	12.9
20 percent or More	10.4	6.7	10.1	8.9
Total	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using 1985 Medicare claims data adjusted for underreporting and aged to 1989. Income information was imputed from the 1984 Health Interview Survey. All nonMedicaid HI and/or SMI enrollees are included.

IMPACT ON ENROLLEES FROM FINANCING PROVISIONS 6/

The three catastrophic proposals differ in the extent to which they would rely on flat versus income-related premiums. Because of this, as well as the different structure of income-related premium rates under the House and SFC plans, the distributional effects are different. The flat and income-related premiums that would be paid by individuals under each of the three proposals are shown, by adjusted gross income (AGI), in Figure 1. 7/

The Bowen plan would rely entirely on flat premiums, with all SMI enrollees paying $81.60 in 1989. Both the House and the SFC plans would rely on a mix of flat and income-related premiums, but the SFC plan would rely more heavily on flat premiums than would the House plan. Over the period from 1988 to 1992, about 43 percent of projected additional premium receipts would come from flat premiums in the SFC plan, while only 19 percent of receipts would be from flat premiums under the House plan (see Table 2 above).

Under the House plan, income-related premiums for individuals in 1989 would be about 8.5 percent of all AGI above $6,258, with the maximum liability capped at $730. Hence, under this plan, the income-related premium would represent a fixed addition to income tax rates, at least up to the ceiling liability. This ceiling would be reached at about $15,000 of AGI for individuals. The average income-related premium paid by enrollees in 1989 would be about $201, and enrollees would pay an additional $31 in new flat premiums. Hence, the total amount paid in Medicare premiums (including the current law premium) in 1989 would be about $507, on average (Table 16).

Under the SFC plan, the income-related premium in 1989 would be about 9 percent of tax liability, up to a ceiling of $850. This would add about 1.5 percent to the tax rate for income in the 15 percent tax bracket,

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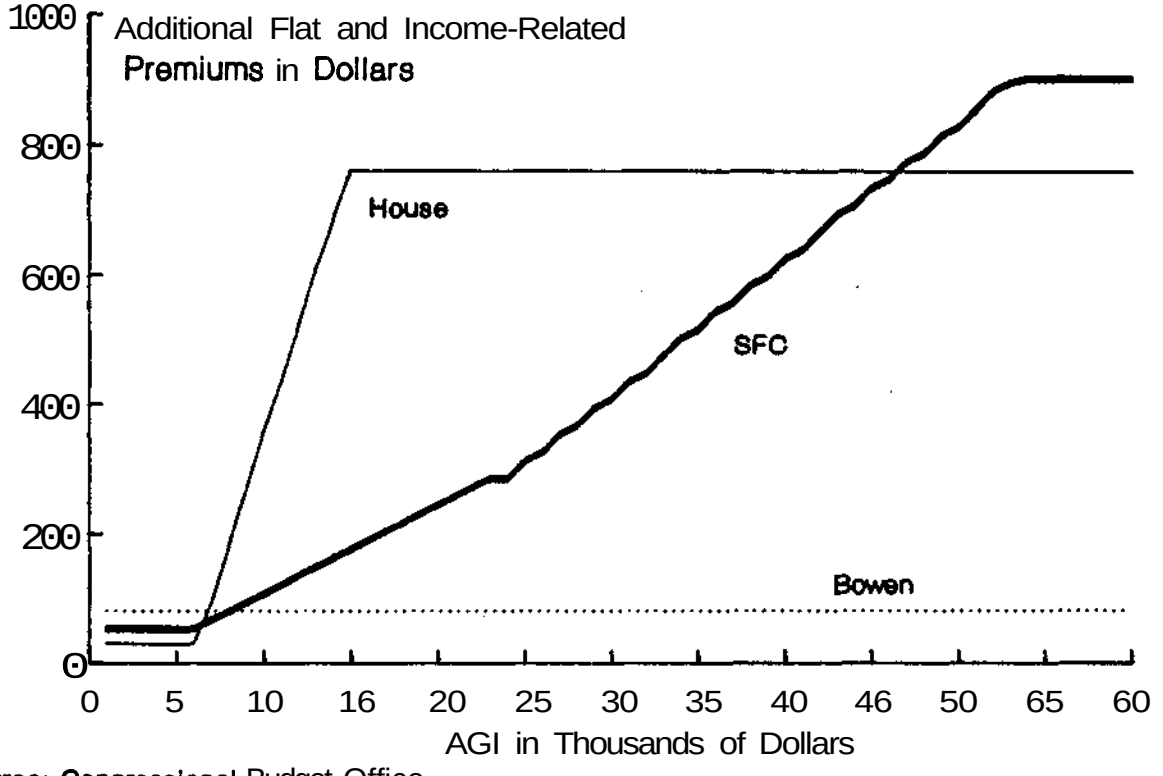
6. Results discussed in this section are based on simulations from the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. The institutionalized population is not included in this survey. Consequently, the sample population differs from the sample population used for the results shown in preceding sections of this paper, because the Medicare claims data do include information about institutionalized enrollees. Results differ from those by the Joint Committee on Taxation because these are based on family income while the JCT results are based on tax unit income; and because these are based on a less inclusive definition of income.

7. The estimates shown in the figure assume that individuals would either claim itemized deductions equal to one-sixth of their AGI or claim the standard deduction (including the extra deduction for the elderly), whichever was larger.

Figure 1, Additional Premiums Under Selected Catastrophic Plans by AGI, 1989



Source: Congressional Budget Office

Note: For single enrollees. Assumes that individuals would either claim itemized deductions equal to one-sixth of AGI or claim the standard deduction, whichever was larger.

TABLE 16. ANNUAL PREMIUM AMOUNTS PAID BY MEDICARE ENROLLEES UNDER SELECTED CATASTROPHIC PROPOSALS, 1989 (In dollars per enrollee)

Component	House Plan	Bowen Plan	SFC Plan
Current Law SMI Premium	275	275	275
New Premiums			
Flat	31	82	54
Average income-related			
For all enrollees	201	0	87
For enrollees with liability	477	0	210
Percent with liability	42	0	41
Average New Premium	232	82	141
Average Total Premium	507	356	416

SOURCE: Congressional Budget Office simulations using the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. All noninstitutionalized HI and/or SMI enrollees are included.

and about 2.5 percent for income in the 28 percent tax bracket. Thus, compared to the House plan, the SFC income-related premium would be a smaller and slightly progressive addition to income tax rates, at least up to the ceiling. The ceiling under the SFC plan would be reached at about $50,000 of AGI for individuals. The average income-related premium paid by enrollees in 1989 would be about $87, with an additional $54 paid in new flat premiums. Under the SFC bill, the total amount paid in Medicare premiums (including the current law premium) in 1989 would be about $416, on average.

Under all of the proposals, lower income groups would pay a disproportionately small share of the costs relative to the benefits they would receive, but this effect is far more pronounced for the proposals that would use income-related premiums for part of the financing than for those that would use only flat premiums. Under the Bowen plan, which would rely entirely on flat premiums, the distribution of costs would mirror the distribution of the enrollee population. Under the Senate Finance Committee

plan, which would impose an additional flat premium of $4.50 a month in 1989 while financing the rest of the costs from an income-related premium, the poor would pay 4.5 percent of costs. They make up 12 percent to 13 percent of the Medicare population, and would receive more than 16 percent of the new benefits. Under the House plan, the poor would pay 1.6 percent of the costs, and would receive 15 percent of the new benefits (Table 17).

TABLE 17. PERCENT OF FLAT AND INCOME-RELATED PREMIUMS PAID BY INCOME AND POVERTY STATUS, 1989

	Percent of Enrollees in Class	Percent of Current Premiums	Percent of New Premiums Paid		
		Current Law	House Plan	Bowen Plan	SFC Plan
By Family Income					
Under $5,000	5.4	5.4	0.8	5.4	2.1
$5,000-10,000	18.7	18.7	2.6	18.7	7.2
$10,000-15,000	14.6	14.6	3.6	14.6	5.9
$15,000-20,000	12.9	12.9	7.8	12.9	6.4
$20,000-30,000	18.4	18.4	18.8	18.4	13.2
$30,000-50,000	18.0	18.0	35.3	18.0	24.0
$50,000 or more	12.0	12.0	30.9	12.0	41.0
By Poverty Status					
Poor	11.7	11.7	1.6	11.7	4.5
Near poor a/	14.7	14.7	2.1	14.7	5.6
Nonpoor	73.6	73.6	96.0	73.6	89.8
Total	100.0	100.0	100.0	100.0	100.0

SOURCE: Congressional Budget Office simulations using the March 1985 Current Population Survey, adjusted for underreporting and aged to 1989. All noninstitutionalized HI and/or SMI enrollees are included.

a. Includes those with incomes above the poverty line but below 1.5 times the poverty line.